

Chaotic and Dangerous:

How the state's poor management of Rainier harms residents with developmental disabilities

May 2019





Table of contents

Table of contents.....	1
Introduction	2
Background.....	4
Disability Rights Washington	4
Purpose.....	4
Oversight Authority	5
Scope and Methodology	6
Rainier Has Not Fixed Long-Standing Problems	7
Rainier still puts people at risk of choking to death	7
Rainier still does not provide required active treatment to residents.....	9
Rainier Must Work to Prevent Sexual Assault.....	10
Rainier Has Serious Structural Deficiencies.....	11
Rainier Is Questionably Transferring Residents Without Protections.....	13
Conclusion	15
About the author.....	15
End Notes	16

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Introduction

This report, *Chaotic and Dangerous*, summarizes The Rainier School's¹ (Rainier) failures over calendar year 2018. Approximately 310 people with developmental disabilities currently live at Rainier and sacrifice a life in the community to receive safe and appropriate care.² Last year, Rainier's failures were so pronounced and serious that the state and federal agencies that oversee Rainier decertified two of Rainier's Program Area Teams (PATs),³ one in May of 2018 (PAT C),⁴ and another in August of 2018 (PAT A),⁵ due to non-compliance with federal standards. This is in addition to the decertification of another PAT in December of 2017 (PAT E).⁶ Decertification means that the federal government stops providing Medicaid funding to the facility. Under federal standards, at least two basic conditions must be met in order to receive funding: people must be safe and people must receive appropriate treatment.⁷

As of publication of this report, PAT E is back in compliance but PAT A remains decertified. Rainier PAT C was re-inspected by RCS and has very recently been recertified.⁸ It is not yet clear whether PAT C's recent recertification involves corrective actions. It is also not clear what will happen in the long term to the residents of PAT A.

In 2018, the state entered into a deal with the federal government to keep PAT E certified while it addressed its deficiencies.⁹ One of the conditions of this deal required the state to hire an independent consultant to review Rainier.¹⁰ The consultant's assessment was scathing, describing the leadership

"In these state-run facilities, DDA does not offer the same services to their clients that similarly situated clients living in the community would get."



of the Developmental Disabilities Administration (DDA) and Rainier as chaotic.¹¹

This should come as no surprise to anyone who has looked closely at Rainier in recent years. In 2017, Disability Rights Washington (DRW) released a report entitled *No Excuses* that exposed a pattern of unsafe conditions and lack of treatment in Washington's four Residential Habilitation Centers (RHCs).¹² One of the four RHCs examined in *No Excuses* was Rainier. DRW found Rainier to present especially serious problems, and thus wrote two more reports in 2018 focusing exclusively on Rainier: *No More Excuses* and *No Excuses for Exclusion*.¹³ *No More Excuses* demonstrated how Rainier continued to endanger the lives of people with developmental disabilities and failed to provide necessary treatment for its residents. *No Excuses for Exclusion* focused on how residents at Rainier are denied high-quality employment and skill building supports that other clients of the DDA get every day. As a result, Rainier residents are excluded from community integrated jobs, paid subminimum wage, and assigned tasks in isolated locations that are not individualized to their abilities.

This year, DRW again revisited the status of care and treatment at Rainier. We looked to a variety of sources, including a report conducted by a state-contracted outside consultant that examined organizational deficiencies at Rainier. Ultimately, DRW concluded that systemic failures, such as disorganized leadership and lack of critical communication, persist at Rainier. These failures continue to seriously endanger people with developmental



Disability Rights Washington's 2018 report, *No Excuse for Exclusion*



disabilities and it is imperative that the state address the current situation immediately. The state is risking the health and safety of Rainier residents and is disregarding its own liability for both individual and systemic failures.

Background

Disability Rights Washington

Each state and territory has an independent advocacy organization with a federal mandate to ensure the rights of people with disabilities are protected and they are not abused or neglected. In Washington, Disability Rights Washington is that organization as it has been designated Washington's Protection and Advocacy System by the governor.

This report was created by Disability Rights Washington's Treatment Facilities Program, which focuses on the delivery of services to people receiving services in institutionally-based residential facilities that generally serve 16 or more individuals. The Treatment Facilities Program advocates for the effective delivery of treatment in humane and therapeutic conditions.

Purpose

The purpose of this report is to not only describe the continuing harm that people with developmental disabilities experience at Rainier, but to also expose the grave, systemic failures on the part of the Rainier leadership and beyond. This report aims to show that the problems at Rainier are not caused by a few bad apples, but rather grow

“This report aims to show that the problems at Rainier are not caused by a few bad apples, but rather grow from organizational structures requiring drastic transformation.”



from organizational structures requiring drastic transformation. While this report will refer to prior DRW reports about Rainier, its purpose is not to simply repeat the same information, but to give an update on conditions at Rainier *and* to reveal new, important information about structural deficiencies. We hope the public, administrators, and policymakers will use this information to make more informed decisions on how to address deficiencies at Rainier.

Being safe in your own home is the most basic expectation any human being has. People living at Rainier are no different. Rainier exists for the sole purpose of supporting individuals in achieving their highest level of abilities. However, the ability to keep residents safe and to provide the appropriate services to residents will be unachievable until serious changes occur—not only at Rainier, but also in how the state invests in and designs residential supports for people with intellectual and developmental disabilities.

Oversight Authority

The Centers for Medicare & Medicaid Services (CMS) is part of the federal government's Department of Health and Human Services, and is responsible for ensuring state compliance with federal statutory and regulatory requirements for state facilities.¹⁴ Each state conducts inspection and investigation surveys on behalf of CMS. In Washington, Residential Care Services (RCS) is the state agency that conducts required inspections and surveys on behalf of CMS to license and certify long-term care facilities, including Rainier.¹⁵ RCS conducts surveys of RHCs like Rainier at least every 15 months.¹⁶

Generally, RCS submits a "Statement of Deficiencies" (SOD) to a facility if a federal requirement, called a condition of participation, is not met. The facility responds with a "Plan of Correction" (POC) to address each and every



deficiency.¹⁷ If the facility does not fix the unlawful conditions of care, RCS will send a letter to notify the facility of an enforcement action including a denial of payment for new admissions.¹⁸



Part of Rainier's outside campus, as seen from staff parking lot.

Scope and Methodology

The problems described in this report come from various sources. Some are pulled directly from the surveys and findings of RCS from both 2018 and early 2019. There are also references to the findings contained within DRW's earlier reports on Rainier. This report also includes information from Rainier's own five-day investigations.¹⁹ Finally, after portions of Rainier were decertified, the state's Developmental Disabilities Administration (DDA) and the federal CMS reached settlement agreements to maintain Rainier PAT E as certified.²⁰ DDA also agreed to hire a consultant, Westcare Healthcare Management (Westcare), to perform a root-cause analysis of problems in PAT E.²¹ This report draws from Westcare's conclusions.



Rainier Has Not Fixed Long-Standing Problems

Rainier staff are legally responsible for creating and implementing plans to keep residents safe. Failure to do so in the past has resulted in sexual assault, choking to death, malnourishment, and lack of medical care.²² Despite DRW's multiple reports exposing such abuse and neglect, Rainier residents remain at serious risk of choking to death or other forms of abuse and neglect.

Additionally, Rainier still fails to provide legally-required disability services to its residents. This results in individuals being warehoused instead of learning new, important skills. The federal government decertified portions of Rainier last year, due in part to its repeated, pervasive failure to provide legally-mandated treatment. There are no signs that Rainier has substantially improved.

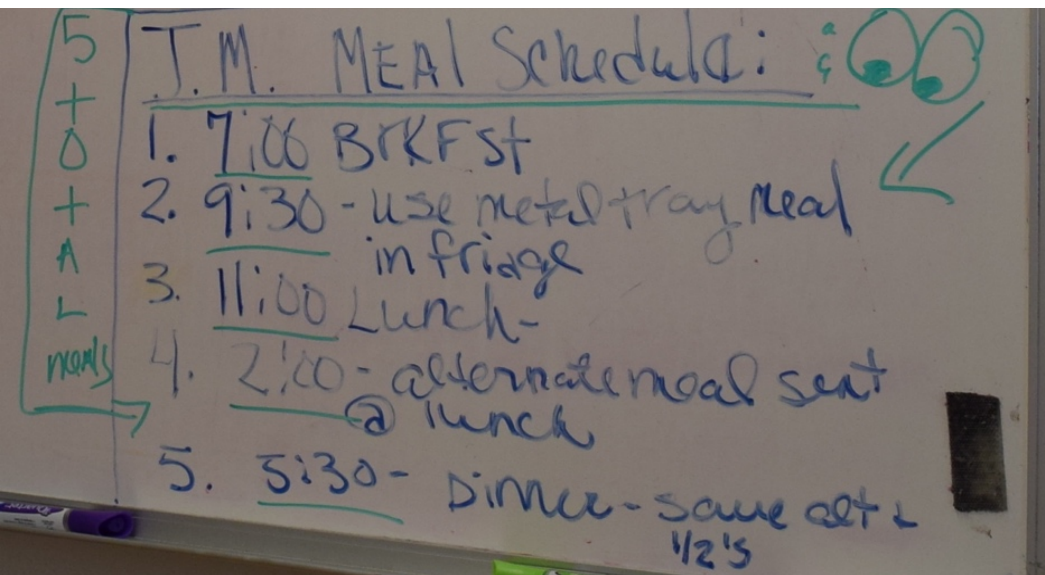
Rainier still puts people at risk of choking to death

DRW's earlier 2017 report, *No Excuses*, recounts how two men choked to death while under Rainier's care almost a year apart because Rainier staff failed to follow the men's prescribed dietary plans.²³ DRW's next report in 2018, *No More Excuses*, again described how Rainier continued to endanger residents' lives in this manner.²⁴ It is unfortunate and upsetting to report that Rainier continued to jeopardize residents' lives throughout 2018 by not following prescribed dietary plans.

For example, one particular resident started vomiting and was taken to the hospital in 2017, where staff discovered that he had eaten food not allowed by his approved diet.²⁵ Then, in January 2018, the patient ingested food outside of his diet texture once again.²⁶ Approximately three weeks later,²⁷



and then *again* one week after that,²⁸ staff discovered that the same individual had again eaten outside his diet texture. Surveys revealed that this man was put at severe risk of choking *four* times, demonstrating how staff did not improve their precautions, even after taking the individual to the hospital for ingesting food outside of his diet texture.



A resident's meal schedule posted in their residence for staff review.

In 2018, Rainier staff fed another resident food outside her prescribed diet, causing the woman to have a choking incident.²⁹ For another gentleman, state surveyors found that he consumed food outside of his approved diet texture twice, with the incidents only one week apart.³⁰ The latter incident involved him eating whole apples he found on the facility grounds. State surveyors found that there was no risk/benefit analysis of his free access to the campus, before or after the two incidents. Then, on January 9, 2019, state surveyors witnessed another patient being served food with inappropriate texture, placing the patient at risk for choking.³¹

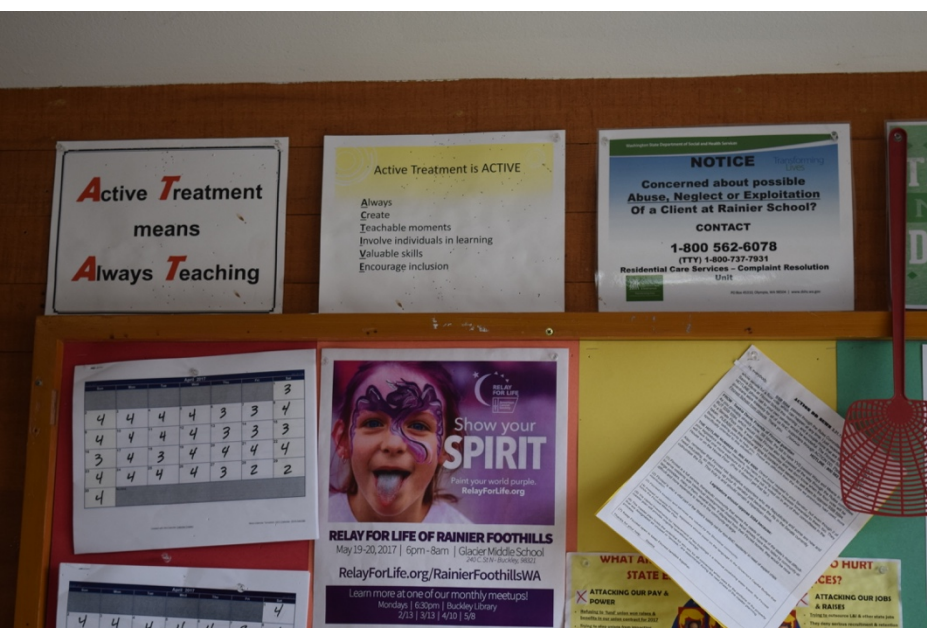
Rainier failed to provide enough staff and send necessary dining protocols (plans that dictate safe food texture for residents) on five different off-campus



trips in 2018, putting residents at risk of serious harm.³² This is particularly concerning given that a man died at Rainier in 2015 during an off-campus trip because his dietary protocol was not followed.³³ It appears that no matter how many warnings staff receive or serious incidents they experience, Rainier continues not to follow residents' prescribed diets, putting residents at risk of choking to death.

Rainier still does not provide required active treatment to residents

Federal law requires Rainier to provide "active treatment" to residents.³⁴ Active treatment is meant to help Rainier residents work towards living more independently.³⁵ In order to provide active treatment, staff first assess an individual's abilities and skills and then create and implement written plans to build upon those skills.³⁶ The plans might include teaching an individual how to communicate more effectively or how to feed or bathe oneself. DRW's prior reports exposed how Rainier is systematically failing to provide active treatment to residents.³⁷



Bulletin board with two signs about active treatment above it posted in a Rainier building.



The RCS inspection of PAT A released in early 2019 revealed two important things. First, Rainier continues to fail to ensure that staff are providing active treatment.³⁸ Second, Rainier attempted to discharge at least one resident by concluding certain residents no longer required active treatment.³⁹ This determination was made without following appropriate policies and meant that the affected resident was erroneously deemed ineligible to stay at Rainier.⁴⁰

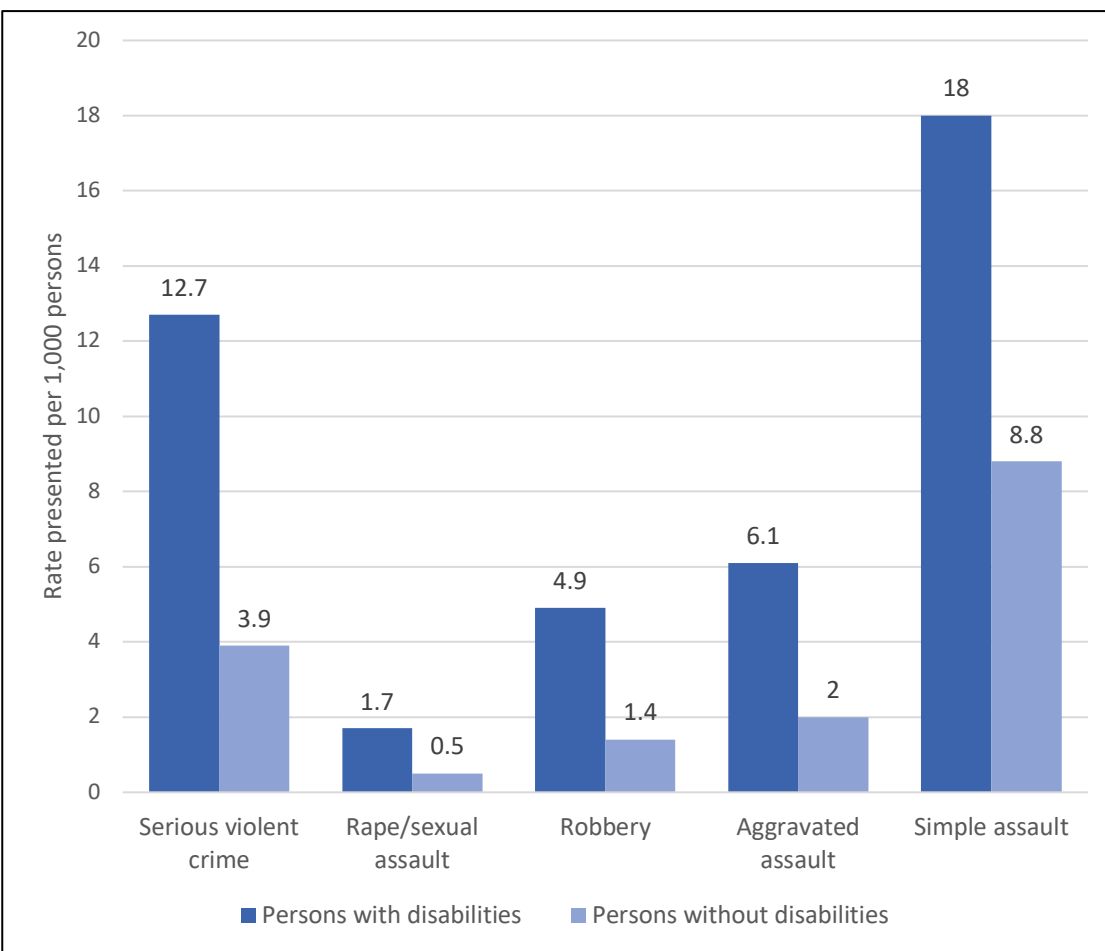
Rainier Must Work to Prevent Sexual Assault

Last year, a former Rainier supervisor was convicted of attempted rape of a Rainier resident and of taking “indecent liberties” with another Rainier resident.⁴¹ The court sentenced the former supervisor, Terry Wayne Shepard, to at least 24 ½ years in prison.⁴² Shepard was discovered when one of his subordinates walked into a victim’s room and found Shepard appearing to have sexual intercourse with the resident.⁴³ The next day, another Rainier resident told staff that he had also sexually abused her.⁴⁴ Shepard worked at Rainier for 34 years before being discovered.⁴⁵ One of the victim’s sisters filed a \$10 million dollar lawsuit against the state, alleging, among other things, that Rainier failed to protect her sister and properly supervise Shepard.⁴⁶

The most recent U.S. Bureau of Justice Statistics National Crime Victimization Survey found that the rate of serious violent crime (rape or sexual assault, robbery, and aggravated assault) for persons with disabilities was more than three times the rate for persons without disabilities.⁴⁷ Among both males and females, those with cognitive disabilities had the highest rate of total violent victimization among the disability types measured.⁴⁸ Unpublished U.S.



Department of Justice data indicates that people with intellectual disabilities are seven times more likely to be sexually assaulted than people without intellectual disabilities.⁴⁹ Given these statistics and what happened with Terry Wayne Shephard, Rainier must take its duty to protect residents against the risk of sexual assault very seriously.



Bar chart showing rate of violent crime against persons with and without disabilities, by type of crime, 2010-2015.⁴⁷

Rainier Has Serious Structural Deficiencies

The state hired Westcare Healthcare Management in 2018 as a result of the settlement agreement between DDA and CMS to keep PAT E certified.

Westcare conducted a root-cause analysis of some of the failures discussed in this report.



Westcare focused partly on the state of Rainier's governing body and determined that it had many deficiencies.⁵⁰ Rainier could not produce written policies outlining the responsibilities of each level of the governing body.⁵¹ Additionally, Westcare found many instances of organizational chaos, constant and many times contradictory directives from DDA, confusion of roles and weak leadership at Rainier, confusion about the chain-of-command between the DDA and Rainier including within PAT E itself, a general lack of responsibility for decision-making from any level of governing body, and PAT E staff who were frozen, cue dependent and frustrated.⁵² When focusing on the relationship between Rainier and DDA, Westcare noted that it appeared "at times confusing and contentious."⁵³ Due in part to such organizational dynamics, Westcare concluded that Rainier has drifted far from the models state and federal regulations expect.⁵⁴

Westcare also noted deficiencies at Rainier in the design and provision of active treatment.⁵⁵ For instance, Westcare found that Rainier siloed assessment teams instead of allowing true interdisciplinary treatment team functioning.⁵⁶ The result was that "no assessment informed another and so on, making treatment scarce, disjointed, and unreliable."⁵⁷ Westcare concluded that these and other breakdowns in the delivery of active treatment resulted in numerous problems, including: program objectives being met for residents but remaining unchanged; program objectives not being met, but the skill difficulty nevertheless increasing; and program objectives that were too difficult for an individual but were not adjusted.⁵⁸

After describing all of their findings, Westcare concluded, "many structural changes will need to be made [at Rainier] to keep within the spirit of federal ICF program."⁵⁹



Rainier Is Questionably Transferring Residents Without Protections

The Rainier leadership harshly criticized in the Westcare report recently devised a questionable plan to move dozens of Rainier residents. RCS looked at some of the initial moves in its October 2018 survey and found that residents are being transferred without appropriate safeguards.⁶⁰ Safeguards are vital because they protect individual rights and autonomy. However, Rainier's policy *Procedure for Movement* does not require that residents and their guardians be included in decisions about moving them from one living unit to another, does not require identifying any potential risks or benefits of a move, and does not provide transition planning prior to the transfer.⁶¹

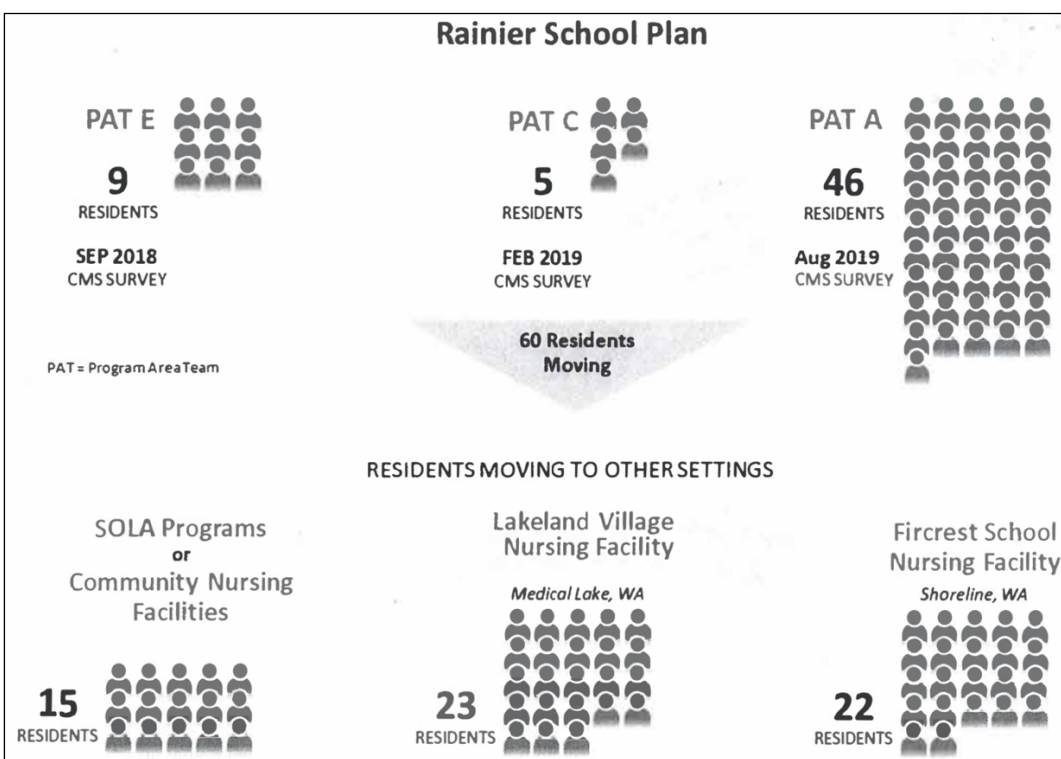
DDA and Rainier are also planning to transfer dozens of residents not just from one part of the facility to another, but out of the facility entirely.⁶² DDA is currently assessing 60 residents to determine whether they are still eligible for active treatment.⁶³ Those found ineligible will be transferred out of Rainier, most likely to a nursing facility.⁶⁴ For some residents, this could involve moving across the state with no guarantee that they will be close to relatives.

A graphic from an August 2018 DSHS document, pictured below, shows how many residents DSHS planned to move out of Rainier after assessment for active treatment eligibility.⁶⁵ This suggests that Rainier predicted a finding of ineligibility for these residents, calling into question the objectivity of any such assessment.

DRW is concerned that the plan to transfer dozens of Rainier residents to nursing facilities is motivated more by concerns over staffing levels and CMS



certification than by individualized assessment and actual resident need. Rainier must either reduce the number of residents or increase the number of staff in order to comply with relevant regulations and regain or maintain CMS certification. Westcare's report found inadequate staffing levels at Rainier, caused by the 2009 budgetary crisis, with a staff:client ratio of 1:6 instead of the generally accepted ratio of 1:3.⁶⁶ Poor staffing ratios places residents in danger and makes the staff's responsibilities more difficult, including delivery of active treatment.⁶⁷ It is likely that reducing the number of residents is generally cheaper for DDA than hiring additional staff. Thus, any decisions Rainier may make about which residents deserve to stay and which must go are inherently suspect.



Graphic taken from an August 2018 DSHS flyer showing the number of residents who purportedly no longer need active treatment and therefore should be moved to other facilities, prepared by DSHS Facilities, Finance, and Analytics Administration.

Indeed, the recent 2019 RCS survey revealed that PAT A erroneously determined that at least one resident was to be discharged due to a determination that the person no longer qualified for active treatment when



in fact they still did.⁶⁸ While the results of DDA's mass re-assessment of Rainier residents is not yet clear, there are troubling signs that should not be ignored and instead calls for close external, independent scrutiny.

Conclusion

Despite numerous reports and warnings, and the loss of CMS certification, Rainier has not improved vital conditions for Rainier residents and continues to expose residents to the risk of death or serious injury. It also fails to provide residents with services that could ultimately enable them to live more independently in a less restrictive setting, including in the community close to family. More recently, serious questions have been raised about whether Rainier is protecting residents' rights when moving them. Evidence indicates that all these deficiencies are structural in nature rather than the result of a few bad actors. The state must take immediate action in order to protect residents and provide them the services they need and deserve and to which they are legally-entitled.

About the author



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End Notes

¹Rainier School [hereinafter Rainier] is a state-run Residential Habilitation Center (RHC) for people with developmental disabilities. The Washington state Department of Social and Health Services' (DSHS) Developmental Disabilities Administration (DDA) oversees the operation of services at Rainier to meet the needs of people with developmental disabilities. Rainier provides vocational training and employment by employing some residents. *See* WASH. STATE DEPT OF SOC. & HEALTH SERVS., DEVELOPMENTAL DISABILITIES ADMIN, RAINIER SCHOOL, <https://www.dshs.wa.gov/dda/consumers-andfamilies/rainier-school> (last visited March 29, 2019).

² *Id.*

³ PATs consist of several buildings, each housing approximately a dozen Rainier residents.

⁴ Letter from Maryann Lindeblad, Medicaid Dir., State of Wash. Health Care Auth., to Jeff Flesner, Acting Superintendent, Rainier School (May 23, 2018), https://www.dshs.wa.gov/sites/default/files/DDA/Rainier%20PAT%20C%20Decertification%20Notice_05%2023%2018_FINAL.pdf.

⁵ Letter from Maryann Lindeblad, Medicaid Dir., State of Wash. Health Care Auth., to Jeff Flesner, Acting Superintendent, Rainier School (Aug. 6, 2018), <https://www.dshs.wa.gov/sites/default/files/DDA/Rainier-PAT-A-MedicaidTerminationNotice-August-6-2018.pdf>.

⁶ Lisa Copeland, *DSHS enters into settlement agreements with CMS for two residential habilitation centers*, WASH. STATE DEPT OF SOC. AND HEALTH SERVS. (May 15, 2018), <https://www.dshs.wa.gov/sesa/office-communications/media-release/dshs-enters-settlement-agreements-cms-two-residential-habilitation-centers>.

⁷ *See generally* 42 U.S.C. § 1396d(d); 42 C.F.R. §§ 483.400-483.480. Additionally, as recognized by the legislature, no matter where people live, they have a right to be protected from abuse and neglect. *See generally* RCW 74.34.005.

⁸ E-mail from Jaclyn Ford, Unit Manager, Residential Care Servs., to author (March 28, 2019, 08:24 PST) (on file with author).

⁹ *Supra* note 6.

¹⁰ *Id.*

¹¹ *See generally* WESTCARE HEALTHCARE MANAGEMENT: RAINIER RHC (2018).

¹² Under Washington State law, the RHCs were established to provide individuals with developmental disabilities “residential care designed to develop their individual capacities to their optimum” and “to insure a comprehensive program for the education, guidance, care, treatment, and rehabilitation of all persons admitted to residential habilitation centers.” RCW 71A.20.010.

¹³ DISABILITY RIGHTS WASH., NO MORE EXCUSES: SHINING A SPOTLIGHT ON ABUSE AND NEGLECT OF PEOPLE WITH DEVELOPMENTAL DISABILITIES LIVING AT RAINIER (2018), <https://www.disabilityrightswa.org/wp-content/uploads/2018/01/FINAL-Jan-2018-No-More-Excuses-Shining-a-spotlight-on-abuse-and-neglect-of-people-with-developmental-disabilities-living-at-Rainier.pdf>; DISABILITY RIGHTS WASH., NO EXCUSE FOR EXCLUSION: SEGREGATION AND



SUBMINIMUM WAGE AT RAINIER (2018), <https://www.disabilityrightswa.org/wp-content/uploads/2018/10/NoExcuseForExclusion-Report.pdf>.

¹⁴ See CENTERS FOR MEDICARE & MEDICAID SERVS., QUALITY, SAFETY & OVERSIGHT, <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/index.html> (last visited March 29, 2019) (stating “CMS maintains oversight for compliance with the Medicare health and safety standards for laboratories, acute and continuing care providers [...] The survey (inspection) for this determination is done on behalf of CMS by the individual State Survey Agencies. The functions the state performs for CMS under the agreements in Section 1864 of the Social Security Act (the Act) are referred to collectively as the certification process.”).

¹⁵ See WASH. STATE DEPT OF SOC. & HEALTH SERVS., RESIDENTIAL CARE SERVS., <https://www.dshs.wa.gov/altsa/residential-care-services/residential-care-services> (last visited March 29, 2019) (stating “RCS is responsible for the licensing and oversight of adult family homes, assisted living facilities, nursing facilities, intermediate care facilities for individuals with intellectual disabilities, and certified community residential services and supports.”).

¹⁶ See 42 C.F.R. § 488.308; see also letter from Survey and Certification Reg'l Office Mgmt., Centers for Medicare & Medicaid Servs., to State Survey Agency Dirs., Intermediate Care Facilities for the Intellectually Disabled (ICF/IID) (Feb. 8, 2013), <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-11.pdf>.

¹⁷ See CENTERS FOR MEDICARE & MEDICAID SERVS., QUALITY, SAFETY & OVERSIGHT-ENFORCEMENT, <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationEnforcement/index.html> (last visited March 29, 2018).

¹⁸ See 42 C.F.R. § 442.118; see also, e.g., *supra* notes 4, 5.

¹⁹ Whenever an incident takes place at Rainier School that may have endangered the physical and mental health of a resident, staff must submit incident reports. Some incident reports become formal five day investigations.

²⁰ *Supra* note 6.

²¹ *Id.*

²² See, e.g., DISABILITY RIGHTS WASH., NO MORE EXCUSES: SHINING A SPOTLIGHT ON ABUSE AND NEGLECT OF PEOPLE WITH DEVELOPMENTAL DISABILITIES LIVING AT RAINIER 8 (2018), <https://www.disabilityrightswa.org/wp-content/uploads/2018/01/FINAL-Jan-2018-No-More-Excuses-Shining-a-spotlight-on-abuse-and-neglect-of-people-with-developmental-disabilities-living-at-Rainier.pdf>.

²³ DISABILITY RIGHTS WASH., NO EXCUSES: SHINING A LIGHT ON ABUSE AND NEGLECT OF PEOPLE WITH DEVELOPMENTAL DISABILITIES IN WASH.'S INSTS. 9-10 (2017), https://www.disabilityrightswa.org/wp-content/uploads/2017/11/NoExcuses_July2017.pdf.

²⁴ See generally *supra* note 22.

²⁵ DEVELOPMENTAL DISABILITIES ADMIN., 5-DAY INVESTIGATION REPORT, INCIDENT REPORT NUMBER 909062 (2017).



²⁶ DEVELOPMENTAL DISABILITIES ADMIN., 5-DAY INVESTIGATION REPORT, INCIDENT REPORT NUMBER 914523 (2018).

²⁷ DEVELOPMENTAL DISABILITIES ADMIN., 5-DAY INVESTIGATION REPORT, INCIDENT REPORT NUMBER 914539 (2018).

²⁸ DEVELOPMENTAL DISABILITIES ADMIN., 5-DAY INVESTIGATION REPORT, INCIDENT REPORT NUMBER 914530 (2018).

²⁹ DEVELOPMENTAL DISABILITIES ADMIN., 5-DAY INVESTIGATION REPORT, INCIDENT REPORT NUMBER 857797 (2018).

³⁰ RCS Statement of Deficiencies (hereinafter “SOD”) and Plan of Corrections (hereinafter “POC”) for survey from Oct. 12, 2018, Rainier PAT E, 12-13 (finding violation W159 *citing* 42 C.F.R. § 483.430(a)). Unfortunately, this survey is not available online.

³¹ RCS SOD and POC for survey dated Jan. 15, 2019, Rainier PAT A, 78-9 (finding violation W 474 *citing* 42 C.F.R. § 483.480(b)(2)(iii)), <https://fortress.wa.gov/dshs/adsaapps/lookup/RCSForms/ICFIID/8800/inspection/2019/R%20B2M313%20SOD%201-15-2019.pdf>.

³² RCS SOD and POC for survey dated April 19, 2018, Rainier PAT C, 2-3 (finding violation W 104 *citing* 42 C.F.R. § 483.410(a)(1)), <https://fortress.wa.gov/dshs/adsaapps/lookup/RCSForms/ICFIID/8802/inspection/2018/R%20Rainier%20Pat%20C%20KPOS12%204-19-18.pdf>.

³³ *Supra* note 23, at 9.

³⁴ Under federal law, Rainier must provide active treatment, which is defined as “a continuous...program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services...that is directed toward...[t]he acquisition of the behaviors necessary for the individual to function with as much self-determination and independence as possible...” 42 C.F.R. § 483.440(a)(1).

³⁵ *Id.*

³⁶ *See supra* note 22, at 17.

³⁷ *Id.* at 18.

³⁸ *Supra* note 31, at 1, 16, 23, 26, 29, 48.

³⁹ Staff stated in an interview by RCS that a resident was confirmed for discharge in error and did not know why the DDA Central Office identified the resident to be discharged in the first place. *Id.* at 10.

⁴⁰ Additionally, RCS review of the proposed facility policy on discharge planning revealed that it did not include the procedure Rainier used to assess residents for active treatment eligibility. *Id.* This is important to note because the proposed policy is meant to protect residents from being discharged because of inaccurate assessments. *Id.* at 9-10.

⁴¹ Ariane Lange, *Unspeakable: An Autistic Woman’s Family Says The State Exposed Her To Sexual Abuse*, BUZZFEED NEWS (July 23, 2018, 8:01 AM), <https://www.buzzfeednews.com/article/arianelange/maryann-stallone-rainier-school-terry-wayne-shepard-abuse>.



⁴² KOMO News Staff, *Ex-supervisor gets 24 ½ years for sexually assaulting autistic woman*, KOMO NEWS (Oct. 26, 2018), <https://komonews.com/news/local/ex-supervisor-gets-24-12-years-for-sexually-assaulting-autistic-woman>.

⁴³ Joseph Shapiro, *'She Can't Tell Us What's Wrong'*, WBUR NEWS (Jan. 10, 2018), <https://www.wbur.org/npr/566608390/she-can-t-tell-us-what-s-wrong>.

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ Q13 News Staff, *Former Rainier School supervisor gets at least 24 years for attempted rape*, Q13 FOX (Oct. 26, 2018, 4:38 PM), <https://q13fox.com/2018/10/26/former-rainier-school-supervisor-gets-at-least-24-years-for-attempted-rape/>.

⁴⁷ Erika Harrell, *Crime Against Persons with Disabilities, 2009-2015-Statistical Tables*, U.S. DEPT OF JUSTICE (2017), <https://www.bjs.gov/content/pub/pdf/capd0915st.pdf>.

⁴⁸ *Id.*

⁴⁹ *Supra* note 43.

⁵⁰ The governing body consists of three levels: 1) the Central Office, which includes the DDA, the DSHS and Washington State's Legislative Committees; 2) Rainier's superintendent; and 3) PAT E leadership. *Supra* note 11, at 4.

⁵¹ *Id.*

⁵² *Id.*

⁵³ *Id.* at 6.

⁵⁴ *Id.*

⁵⁵ *Id.* at 12.

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ *Id.* at 14.

⁵⁹ *Id.* at 17.

⁶⁰ *Supra* note 30, at 3-4 (finding violation W104 *citing* 42 C.F.R. § 483.410(a)(1)).

⁶¹ *Id.* at 3-4, 6-10 (finding violation W104 *citing* 42 C.F.R. § 483.410(a)(1) and violations WW124-5 *citing* 42 C.F.R. §§ 483.420(a)(2-3)).

⁶² See *e.g.*, WASH. STATE DEPT OF SOC. AND HEALTH SERV., LEAFLET, MAINTAINING CMS CERTIFICATION AT RAINIER SCHOOL 1 (2018).

⁶³ *Id.*; see also SAGE ARCHITECTURAL ALLIANCE: PREDESIGN STUDY; NURSING FACILITY NEW CAPACITY AT RAINIER SCHOOL, BUCKLEY 1.1, 2.1. (2018), <https://www.dshs.wa.gov/sites/default/files/FSA/capital/Projects/RS-Full%20Report%202018.pdf>

⁶⁴ *Id.*

⁶⁵ *Supra* note 62.

⁶⁶ *Supra* note 11, at 5.

⁶⁷ Incident reports and internal investigations also revealed multiple cases of staff sleeping on the job, including when they are supposed to be watching a particular resident for safety concerns.

⁶⁸ *Supra* note 31, at 9-10 (finding violation W104 *citing* 42 C.F.R. § 483.410(a)(1)).